Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HARRIS METHODIST
PO BOX 916063
ARLINGTON TX 76191-6063

Respondent Name
CITY OF ARLINGTON

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-07-3884-01

MFDR Date Received
February 23, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am filing this MDR to appeal for payment of stoploss and trauma charges at 75% of billed charges, which is $189,242.34 and to preserve our rights. It more than qualifies for stoploss reimbursement of 75% of billed charges over $40,000.00. This claim was also filed with Hartford as a trauma admit (DX 812.51). Trauma codes in the range from 800.0 thru 959.50 are specifically carved out on the fee schedule for a higher rate of payment than the regular per diem rates. Fair and reasonable has been determined to be 75% of billed charges ($189,242.34 in this case). After the insurance payment of $101,309.23, there remains a balance due of $87,933.11."

Amount in Dispute: $87,933.11

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "PPO Discount taken – paid in accordance Rule 134.401(c)(5)(A) Trauma – pd fair + reasonable rate. PPO Issue – Rule 134.202(d)(3)."

Response Submitted by: Specialty Risk Services, Inc. 300 State Street, Syracuse, New York 13202

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 25, 2006 to April 20, 2006	Inpatient Services	$87,933.11	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.

4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – WRKRS COMP STATE FEE SCHEDULE ADJUSTMENT. SUBMITTED SRVCS WERE REPRICED IN ACCORDANCE WITH A FAIR & REASONABLE RATE FOR TRAUMA.
   - 16 – CLAIM/SRVC LACKS INFO WHICH IS NEEDED FOR ADJUDICATION. IN ORDER TO REVIEW THIS CHARGE WE NEED A COPY OF THE INVOICE DETAILING THE COST TO THE PROVIDER.
   - W1 – WRKRS COMP STATE FEE SCHEDULE ADJUSTMENT. REDUCE TO FAIR AND REASONABLE IN ADDITION TO THE NORMAL PER DIEM REIMBURSEMENT ACCORDING TO RULE 134.401(C)(4)(B).
   - 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT. THE CHARGES HAVE BEEN PRICED IN ACCORDANCE TO YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. IF YOU HAVE ANY QUESTIONS PLEASE VISIT WWW.FIRSTHELALTH.COM OR CALL 800-937-6824
   - W1 – WC STATE FEE SCHED ADJUST. REIMBURSEMENT ACCORDING TO THE TEXAS MEDICAL FEE GUIDELINES.
   - G101 – Adjusted to Usual and Customary Fees for this type of service.
   - TX01 – Reimbursed according to Texas Workers' Compensation Commission Medical Fee Guidelines
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT. THE CHARGES HAVE BEEN PRICED IN ACCORDANCE TO YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. IF YOU HAVE ANY QUESTIONS PLEASE VISIT WWW.FIRSTHELALTH.COM OR CALL 800-937-6824." Review of the submitted information found no documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on June 1, 2012, the Division requested the respondent to provide a copy of the referenced contract between the City of Arlington and the alleged network, as well as a copy of the contract between the network and Harris Methodist, pursuant to former 28 Texas Administrative Code §133.307(e)(1), effective December 31, 2006, 31 Texas Register 10314, which states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available." On June 18, 2012, attorneys Flahive, Ogden & Latson responded on behalf of the respondent by facsimile transmission which stated that "The carrier/self-insured has been unable to locate a contract at this time, but will continue searching and supplement." As of the date of this review, the respondent has not provided the additional information requested by the Division; therefore, pursuant to §133.307(e)(1), this decision is based on the information available at the time of this review. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to inpatient hospital services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5), which requires that "When the following ICD-9 diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate: (A) Trauma (ICD-9 codes 800.0-959.50); (B) Burns (ICD-9 codes 940-949.9); and (C) Human Immunodeficiency Virus (HIV) (ICD-9 codes 042-044.9)." Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 812.51. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. Former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(c)(2)(E), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the submitted documentation finds that the requestor has not provided copies of any medical records to support the services in dispute. The

Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).

6. 28 Texas Administrative Code §133.307(c)(2)(F)(i), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "a description of the health care for which payment is in dispute." Review of the submitted documentation finds that the requestor has not provided a description of the health care for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(i).
7. 28 Texas Administrative Code §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iii).
8. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
9. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

   - The requestor's position statement asserts that the claim for reimbursement of disputed services "more than qualifies for stoploss reimbursement of 75% of billed charges over $40,000.00."
   - As noted above, the Division's former *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.401 is not applicable to the services in dispute. Per §134.401(c)(5)(A), when ICD-9 codes 800.0-959.50 are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Therefore, the applicable rule for reimbursement is found under §134.1(c).
   - Moreover, §134.401(c)(6) states that "The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate." As stated above, the Division has found that the primary diagnosis is a diagnosis code specified in §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to §134.1.
   - The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

     "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

     Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	December 27, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.